The Case of "Kim": The Feelings and Experiences of a Bulimic

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Résumé

A travers le cas de "Kim" (pseudonyme), l'article illustre les principaux traits distintifs d'une "bulimique". Pour mettre en lumière ce trouble de manger, on présente des extraits représentatifs d'une suite d'entrevues avec elle. Le cas de Kim est suivi pendant qu'elle apprend à vomir, décide de chercher conseil et durant des séances de thérapie.

Abstract

In this paper the case of "Kim" (a pseudonym) is used to illustrate the main characteristics of a bulimic. To illustrate this eating disorder and Kim's feelings and experiences about it, representative excerpts are taken from a series of interviews with her. Kim is followed through the process of learning to vomit, deciding to seek help, and through therapy sessions.

In this paper, the characteristics of the bulimic are illustrated by reporting excerpts from a series of interviews with Kim. Her thoughts, actions, and reactions provide poignant examples of the nightmare of bulimia. Segments of conversation are supported with documentation from the literature to demonstrate the generality of her concerns and actions. Before proceeding with the case of Kim, the symptoms of bulimia are contrasted and compared with those of anorexia nervosa.

According to the latest Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980), bulimia is considered to be a form of binge eating, accompanied by some degree of awareness of the abnormality of the eating pattern. The word, bulimia, is derived from the Greek concept meaning "ox hunger" or "insatiable appetite." Bulimia has been considered as being closely related to anorexia nervosa (Kubistant, 1982; Polivy & Herman, 1985). There are common symptoms found in people who suffer from bulimia and anorexia nervosa. Victims of both disorders, for example, share an intense fear of becoming fat and they often are obsessed with dieting. In this regard they have accepted the common societal belief that thinness is a highly desired goal; they are rewarded by comments from their peers on their appearance, more specifically their thinness. They are very knowledgeable about nutrition and compulsive about food. Also, in an attempt to control their lives, they usually strive for perfection in other areas, such as their academic achievement or their exercise programs. As a result they tend to be compulsive about the knowledge they are

acquiring in the attempt to be perfect. There are two key differences, however. Bulimics usually have a normal or slightly above normal body weight; anorexics, on the other hand, typically have a lower than normal body weight. The primary characteristic of the former is gorging, whereas in the latter it is starvation (Neuman & Halvorson, 1983). The second difference appears to be in the expressed feelings attached to food. Bulimics love food while anorexics hate it (Stevens & Salisbury, 1984). Both may feel envious of others' ability to stay thin. In addition, both attempt some form of control; however, bulimics likely are embarrassed or even disgusted about the way they attempt weight control. It is after all much more socially acceptable to skip a meal than to vomit.

Kim, aged twenty-one, is a university student, who in the search for the perfect "thin" image has resorted to vomiting to control her weight. She is typical of a fairly large group of individuals who suffer from "bulimia." The incidence rate of bulimia ranges from 1.9% of the general population to 30% of the college population (Neuman & Halvorson, 1983; Stevens & Salisbury, 1984). The vast majority of cases are females in adolescence or their early twenties; however, approximately five to ten percent of reported cases of bulimia are males (Neuman & Halvorson, 1983). Thus, Kim appears representative of a large proportion of bulimics.

THE CYCLE OF THE BULIMIC

Kim, like other bulimics, follows a fairly predictable cycle. First, depression or stress triggers the impulse to eat. After eating, there is the fear of keeping the "extra" calories in her system so she vomits to eliminate the food. After vomiting, Kim usually feels guilt, shame, and disgust accompanied by a sense of loss of control over herself. According to Kubistant (1982), this cycle of bingeing and purging may occur up to five times per day. In addition, Kim, as a compensatory action, follows vomiting by exercise to "do something good for my body."

Bingeing

Bingeing usually is associated with stress, rather than hunger. In addition, consumption is so quick that there appears to be no pleasure associated with food intake, only relief (Neuman & Halvorson, 1983). The act of bingeing normally involves "... a compulsive consumption of large amounts of food, frequently high caloric carbohydrates, accompanied by a feeling of being out of control of the amount ingested. The binge usually takes place when the individual is alone and may last several hours" (Bauer, 1984, p. 221). The choice of food is specific to the individual. Kim has learned to be very selective in what she picks for a binge.

There are certain things that you never want to throw up . . . don't have salts, have sweets. . . . If you are going to vomit eat sweets because it doesn't taste half as bad coming up . . . breads are also okay. If you want to get sick and never do it again . . . try and eat salads because they sure taste gross . . . It hurts . . .

Purging

The methods of purging vary from individual to individual; however, self-induced vomiting seems to be the most common choice (Bauer, 1984). Vomiting is the method of purging used by Kim; however, what is of interest in this case is not the choice of method but that Kim had to learn to vomit. As she reports in the next excerpt, she went to great lengths before she was able to vomit. With effort Kim, however, has learned what she calls the "science" of vomiting.

I really had to work at it. I could not vomit for the longest time. I used to drink mustard and water and try to throw up. I used to drink vinegar. . . . then I tried my finger and all I would do is gag. The first time it must have taken a half an hour of gagging before I got a piece of food up. And then gradually over time, it comes easier. I could go into the washroom right now and throw up really quickly. Because I have learned how to do it. You eat then wait about five minutes, then you have a glass of water and wait a few more minutes, and then you go vomit and it will come up really easy. . . . there is a true science to throwing up.

As vomiting became easier, it also increased in frequency. Kim developed an obsession about food and spent much of her time thinking about eating.

When you go to bed at night all you think about is what you are going to have for breakfast. While you're eating breakfast you think about lunch. While eating lunch you think about snacks or dinner. Your whole life revolves around food . . . You don't even matter . . . you get a really narrow outlook on life, there is no pleasure unless it is with food. . . . it's a horrible feeling.

Obsession with food often leads to being secretive. This secretiveness, which seems to be associated with an overwhelming fear of being detected, may be so encompassing that the desire to binge-purge may result in the bulimic ending primary relationships (Boskind-Lodahl & Sirlin, 1977), although there was no such relationship in Kim's case.

CASE HISTORY LEADING TO BULIMIA

The major events, in summary, that Kim saw as being the most closely associated to the onset of her eating disorder are (a) the death of her mother, (b) the immediate remarriage of her father, (c) resultant and new responsibility for house care, and (d) difficulty in school.

In addition, Kim had been battling what she considered to be her tendency to be overweight for about three years. Three years prior to her mother's death, Kim had weighed 118 pounds, which was distributed over a frame of five feet and six inches. During her first year in university

her weight increased to 150 pounds. Although she lost some of that weight, she states that "I never felt slender again." In her second year, still before her mother died she reduced her weight to 132 pounds, but she felt "it was still a long ways from 118 pounds." In that year when Kim was nineteen, her mother died.

Following the death of her mother and the remarriage of her father, at the beginning of her third year when she was twenty, Kim again decided to diet. She sought the advice of a nutritionist and began to lose weight successfully for a period of time. This weight loss did not continue, however. Kim seemed to reach a plateau that she could not break. She still wanted to lose weight and in reading an exercise magazine happened on an article on eating disorders. This information became the immediate incentive for trying vomiting as a weight control technique. She states,

> I never really had an urge to throw up. What happened was I read it and thought it was a good idea and tried it... I was so desperate I didn't know where else to turn. I thought if I could control nothing else... weight could... should be controllable.... I felt out of control... I did not know where I was going at school... I felt I was losing my father... My mother was not there.... I felt totally lost. I couldn't control anything... I looked at bulimia as a means of control.

Thus, while stress contributed to her feelings, reading about bulimia lead her to try vomiting. Kim, then, learned how to vomit.

The chain of events that followed are described in the first paragraph in this section. To what extent these factors directly contributed to bulimia in Kim's case are unknown. Two points are worth emphasizing, however. First, Kim experienced what she believed to be complete rejection by her father. For example, she states "I felt so alone, he didn't even phone me when he came to town." Second, while she was concerned about her grades, Kim spent five times as much time exercising as studying. Exercising had become part of the cycle weight control through vomiting.

SEEKING HELP

Kim maintained an uninterrupted pattern of bingeing and purging for six months. Towards the end of this time period, in the middle of a cycle of bingeing and purging, Kim decided that she wanted to stop vomiting and to stop she needed help. She explains her realization of the need for help in the following statement.

> The biggest step I ever took was when I said "I got to get help"... You know the little mall? I went through the mall... I stopped and bought a candy bar at the delicatessen then went into the bakery and bought a cinnamon bun and a muffin, and then wandered into the grocery store and bought two Cadbury

chocolate bars and then ate all those going up the hill and then.... got sick, and then immediately walked across to Health Services to say that "I have a problem" and asked them for help.

The initial reaction to her request for help was not very encouraging. She was told that she looked fine and that she should just stop vomiting. Like most other bulimics, she knew the risks associated with vomiting. Kim knew she wanted to stop but she also could not control her behaviour. Again, this pattern displayed by Kim seems representative of the inability of bulimics to control their eating behaviour (Mallick, 1984).

Leaving university for the summer, she sought the assistance of her family doctor. While he knew little of bulimia, he did refer Kim to a local psychiatrist. This was the beginning of learning not to vomit.

The psychiatrist did not talk about bulimia with Kim, rather the conversation focused on other things. Avoidance of "food talk" has been identified by the National Association of Anorexia and Associated Disorders (1984) as being instrumental to treatment. Bauer (1984) adds that the emphasis must be on the pressure the person feels that leads to the cycle of bingeing and purging rather than on eating itself.

Even in the beginning of Kim's individual therapy avoiding talk about food and focusing on other issues was instrumental in stopping vomiting for a short period. In Kim's words, the psychiatrist "did not talk to me about food... he talked to me about my family, about stress and control. That helped. After the first week I didn't vomit for a whole week!" "He gave me what I had been missing, confidence in myself." Thus, not talking about food was important to Kim.

While professionals began to play an important role in ending the binge-purge cycle, casual friends were important. The choice here was crucial to Kim, she did not want to confide in close friends. Although Kim did not explain why close friends were avoided, she did emphasize the importance of talking to someone who was a casual friend. Her choice of confidant was a male she worked with, a person Kim felt was sensitive and caring. She comments,

> I owe so much to him... I told him everything. He would ask me, "Were you good today? Have you vomited?" I would say, "No, I haven't." and he would say, "That's good...". You need support like that, someone you can tell... if I said I did vomit... he would ask why and I would tell him... he would say, "Okay, but you won't do it anymore...". I'd say, "No.". Then he would say, "but if you do... call me... please call me..." That was really good that he cared enough.

Perhaps the most important aspect of Kim's choice of confidant is that he was sensitive and caring. Carter and Duncan (1984) point out that bulimics are "both willing and relieved to discuss their problem when a sensitive, open, and understanding person is available" (p. 198).

Professionals continued to be important in breaking the habit of

vomiting. Kim, now aged twenty-one, joined an eating disorders discussion group (e.g., Weber, 1984). The meetings took place once a week and were one hour in length. She also had the option of meeting individually with the counsellor any time she felt the need to talk.

During the first half-hour of the group meeting, Kim participated in a "tell all." This reporting of successes, failures, and feelings was followed by goals being reviewed and reaffirmed. Hornack (1983) suggests that this step of self-analysis and goal setting helps to facilitate treatment.

A "new information" session took place during the last half-hour of the group session. Topics included nutrition, exercise, self-esteem, assertiveness, and the dangers of the disorder. These weekly sessions were for Kim the beginning of a sense of victory over bulimia.

> I was able to say, for the first time in I don't know how long, that I wasn't always thinking about food. I wasn't always thinking about exercise as so many calories burnt... I tell everybody I'm scared of elevators... the reason it all developed was because when I was bulimic... I thought if I could walk upstairs I would burn off more calories... I was obsessed with losing weight....

A final key to Kim's feeling that she is able to gain control over her eating habits again is the buddy system that is one component of her eating disorders group. This buddy serves a similar purpose to her work friend, but the buddy provides Kim with a stronger desire not to vomit. She believes that this other "person is depending on me but if I blow it they're still going to love me, they're still going to be there... but I don't want to blow it... I want to show that I can do it."

SUMMARY AND IMPLICATIONS

Four phases seem to characterize Kim's experience as a bulimic. First, Kim believed that she had lost control over what she considered key elements in her life. Second, she wanted to have control over at least one component, her weight. Controlled dieting did not work, or more appropriately, Kim thought it did not work fast enough. Next, information, obtained in a happenstance manner, lead to experimentation with vomiting. Fourth, once the pattern of bingeing-purging had been learned, the cycle had to be self-consciously interrupted and broken. Kim realized that she needed help and over the period of a year sought and found that help.

At the conclusion of the series of interviews with Kim she still was vomiting. The frequency, however, was reduced considerably to an average of one time per week. Perhaps more important than her continued vomiting was that Kim believed she had the power to stop. At the present time, Kim still is a member of the eating disorders group; however, she is playing a new and additional role. In addition to participating in group counselling, she is acting as an assistant to the counsellor.

There are at least two implications for any professional who interacts with or counsels an individual with bulimia. First, recognition and acknowledgement of a self-referral is the first crucial step toward successful treatment. It was due to Kim's continued persistance that she eventually began counselling. Not everyone will follow Kim's pattern, professionals must be careful not to equate self-recognition of bulimia as meaning a person is capable of self-treatment. Second, the beginning of a successful approach to bulimia in Kim's case involved avoiding discussion of food and focusing on positive steps toward control of the circumstances surrounding her life. Helping Kim to believe that she had self-control became the cornerstone to effective counselling. In summary, we suggest both acknowledgement of the reality of bulimia and a cognitive approach to it are essential in beginning to successfully treat bulimics.

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